ARIZONA STATE BOARD OF PHARMACY
4425 W. Olive, Suite 140
Glendale, AZ 85302-3844
623-463-ASBP(2727) Fax: 623-934-0583
www.pharmacy.state.az.us

CONSUMER COMPLAINT FORM

For Board Use

Complaint # _____
Date _____
Investigator _____
Review Officer _____
Deputy Director _____
File # _____
File Date _____

Your Name _____ Address _____
(number, street and unit)

Your City, State & Zip _____ Phone _____ _____
(daytime) (home)

PHARMACY INVOLVED

Name _____ Address _____

City, State & Zip _____ Phone _____

Prescription Number _____ Date of Prescription _____

Patient Name _____ Name of Medication _____

Pharmacist Name (if known) _____

Physician Name _____ Physician Phone Number _____

BRIEFLY OUTLINE ACTIVITIES LEADING TO THIS COMPLAINT (Use additional page if necessary. Please do not write on back of this page.)

If complaint involves a prescription error, is the evidence available? yes no If so, where? _____

Has the pharmacist been contacted? yes no If yes, what was the result? _____

(circle one) If no, why wasn't contact made? _____

Has the physician been contacted? yes no If yes, what was the result? _____

(circle one) If no, why wasn't contact made? _____

Signed _____ Today's date _____
(your signature)